The Manitoba Medical Association Review

ANNUAL MEETING
AND POST GRADUATE WEEK
WINNIPEG, SEPT. 9-14

IN AFFILIATION WITH
THE CANADIAN MEDICAL ASSOCIATION
THE BRITISH MEDICAL ASSOCIATION

September
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Vol. XV., No. 9

Manitoba Medical Association

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Clinical Section

THE INFUENCE OF CHRONIC GALL BLADDER DISEASE ON THE HEART
with the attending Diagnostic Difficulties

By

CHARLES HUNTER, M.A., M.D. (Aber.)
F.R.C.P. (Lond.)
Professor Emeritus in Medicine
University of Manitoba

I approach this very live problem from the clinical standpoint, with special reference to the role surgery may justifiably play, as the physician sees it.

Many difficulties arise at the outset. Gall bladder disease and cardiac disease are both extremely common in middle and advanced age; Llewellys Barker and Von Bergmann have recently estimated that 30% of all men and 40% of all women, after the age of 40 who come to autopsy, are found to have gall stones, while White points out that, of 3,000 physicians who died in the United States during 1931, over 1,000 died of heart disease.

Such common diseases must often coincide in the same individual; Willius & Brown found in 86 autopsies of coronary sclerosis, gall bladder disease in 26% while Schwartz & Herman recently found in 109 patients with cholecystitis, evidence of associated myocardial disease in 63.3%.

For my purpose, such statistics merely emphasize the great frequency with which both pathological conditions are associated and suggest the necessity for caution in assuming any special influence of one disease on the other.

Difficulties especially arise because our *diagnosis* is frequently at fault; acute cholecystitis is mistaken for cardiac infarction and vice versa: angina pectoris is confused with gall bladder pain. These errors becloud the issue in question —the influence of chronic gall bladder disease on the heart—and must be first dealt with, otherwise unreliable conclusions may be drawn from the results of operative interference, performed under faulty diagnosis.

Such diagnostic errors arise largely from unwarrantably stressing cardiographic and gall bladder visualization findings at the expense of a careful history. In recognizing gall bladder disease of an active type, definite gall bladder colic outweighs all other evidence, while a gassy dyspepsia alone is quite unreliable; non-visualization of the gall bladder by Graham's method and even negative shadows of calculi in a gall bladder may in the absence of confirmatory gall bladder colic have no clinical significance, representing merely the silent gall bladder disease, which is so often met with in the post mortem room. On the other hand, the gall bladder may visualise and yet may be the culprit, as Kirklin finds in 10.5% of his cases—due sometimes to upset of the neuro-muscular mechanism of the extra-hepatic biliary tract and sometimes to a calculus temporarily blocking the cystic duct but allowing at other times free flow of bile into a comparatively normal walled gall bladder.

No doubt, typical gall bladder colic should rarely be confused with heart pain, for the maximal site is usually in the right upper quadrant or in the epigastrium, passing to the back or right shoulder; colicy in character, it is often associated with a sense of extreme distension in the epigastrium and is rarely induced by exercise, the victims being especially women in middle age. But in practice, it is at times extremely difficult to distinguish between severe cholecystitis and coronary thrombosis; in both, the pain comes usually at rest, may be confined to the high epigastrium, may last for hours and be accompanied by restlessness of the sufferer and by rigidity of the upper abdominal muscles. In severe cases of coronary thrombosis, the collapse, the feeble sometimes rapid beat with gallop-rhythm, the breathlessness or even cyanosis, the frequent spread of the crushing pain upwards behind the sternum and even into the arm, the possible history of preceding angina, will usually guide one to the heart; a falling blood pressure early, a leucocytosis and rise of temperature later with possibly a local and passing pericardial rub, may settle a hitherto doubtful diagnosis.

The electrocardiogram is most valuable—sometimes decisive—in doubtful cases, but in general the tracing must be interpreted not as an isolated and authoritative pronouncement but as a useful aid to the history and physical examination, the value of which outweighs the most precise laboratory findings. Thus persistent breathlessness on slight exertion, developing immediately after a doubtful attack of high epigastric pain may in the absence of all other evidence settle the diagnosis in favour of a preceding cardiac infarction.

On the other hand, abnormal cardiographic findings and even definite myocardial disease may be present; breathlessness may be marked and the enlarged liver with a tender edge may seem but the natural result of back pressure from a failing heart, though closer examination may show the hepatic tenderness curiously confined to the gall bladder neighbourhood. Yet recurring attacks of high abdominal colic or at least distress may antedate these cardiac disturbances which now dominate the clinical picture; a sudden frank cholecystitis or a little jaundice following a low-sternal, high epigastric pain of doubtful origin may reveal gall bladder disease, hitherto unsuspected (though jaundice occasionally occurs in cardiac infarction also).

These are the patients about whom Babcock, T. R. Brown and others have written and in my own experience, several such cases have been greatly improved by cholecystectomy. Evidently the gall bladder infection has weakened the myocardium which recovers considerably when the source of infection is removed. But remember, the gall bladder disease must have shown evidence of activity; the mere presence of a non-functioning gall bladder or of gall stones demonstrable on x-ray examination but accidentally discovered, is no reason at all for operative interference, just because the heart shows signs of disease.

It is well to reflect that while gall bladder disease is much more common in women, coronary thrombosis and angina pectoris are much more common in men—hardly an argument for their close interdependence, but rather emphasizing the necessity for critical investigation of individual cases before surgery is seriously considered. Still, it may be laid down as an axiom that *every case of suspected coronary occlusion should be carefully reviewed from the gall bladder standpoint* —one must deliberately consider whether all the symptoms of the supposed heart case might be due to gall bladder disease, or at least whether some of the attacks might be so explained and if so, whether operation be advisable.

The cases of *angina pectoris* must be similarly reviewed. No doubt, typical angina pectoris is easily recognized: a griping, pressing pain—in mild cases, merely an ache or sense of fulness—develops behind the sternum, on exertion especially after a meal or on exposure to cold or under great excitement; the substernal position with possibly radiation to the left, or exceptionally to the right, arm is characteristic—it does not spread downwards into the abdomen or to the back, though it may pass up to the throat. The pain is not sharp and stabbing, though its gripping quality may be modified to a numb, burning or tingling sensation, especially in the arm; it is rarely if ever referred to the apex of the heart or to the left costal margin. The distress is only exceptionally accompanied by a fear of impending death, in my experience; it disappears rapidly when the patient stands still or slows up and nitroglycerine, grain 1/100, hastens its disappearance; the pulse rate and rhythm are usually normal in an attack; the average blood pressure in 100 cases was found by Levine to be 160 with diastolic of 95; the condition occurs most frequently in men over 50.

Too much reliance has been placed on the cardiogram in doubtful cases; it is now known that some 20% of all cases of angina pectoris show no abnormality in the electrocardiogram and for that matter, physical examination including an x-ray of the chest may be equally negative — the history again is the only clue to the diagnosis in these cases.

I have emphasized the symptoms of angina pectoris partly because one finds that recurring cholecystitis is sometimes mistaken for angina pectoris and surgery obviously indicated is thereby indefinitely postponed but especially because both chronic cholecystitis and angina pectoris may coincide in the same patient and *marked improvement or even disappearance of the anginal symptoms may follow a successful cholecystectomy*.

In general, one may say that underlying angina pectoris, there is organic disease of the coronary arteries, with some interference to the supply of blood to the heart. Such coronary disease, however, may in certain cases be insufficient to produce symptoms of angina pectoris, unless an additional factor be present such as marked anæmia, mitral stenosis or hyperthyroidism. Now the diseased gall bladder also provides just such an added factor in some cases. Certain it is that one sometimes gets a history of undoubted cholecystic attacks, intermingled later with undoubted anginal seizures—an angina which is relieved or cured for years at least, by cholecystectomy. Of this truth, I have personally had a number of examples. It would seem that from the upper abdomen, stimuli may arise, which reflexly increase the tone of the coronary arteries, dimishing the flow of blood through them to the cardiac muscle — a flow already narrowed by coronary disease. Timely cholecystectomy by getting rid of this reflex stimulation, improves the cardiac circulation, just as a sympathectomy in suitable cases of thrombo-angeitis obliterans may greatly improve the peripheral circulation by removing all associated spasm.

Nor is the risk of operative interference greatly increased in the presence of angina pectoris; thus Butler, Feeney and Levine record 41 operations performed on 35 patients with angina pectoris, with only 3 unexpected deaths, while Judd, of Rochester, does not hesitate to do a cholecystectomy on any case of angina pectoris, who would otherwise require it, provided the patient is adequately prepared for operation.

Butler's statistics, however, do show that if a patient is operated on under the mistaken diagnosis of an abdominal emergency — severe cholecystitis, perforated ulcer, acute pancreatitis —when the symptoms are really due to an acute coronary thrombosis, the death rate will be exceedingly high. This but emphasizes the necessity for correct diagnosis in cardiac v. high abdominal emergencies; with the diagnosis assured, the clinician then tries to evaluate if active gall bladder disease adds to the burden of an associated myocardial weakness or to the frequency of an associated angina pectoris and finally he must decide if cholecystectomy, or at a pinch, cholecystotomy is indicated.

"Treatment is an art—but it is an art that should have an underlying scientific basis, or at least intelligent idea, and there should be no ingredient in the treatment the inclusion of which cannot be justified if questioned."—E. W. Giesen.

Editorial and Special Articles

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MINUTES of a meeting of the Winnipeg members of the Executive of the Manitoba Medical Association held in the Medical Arts Club Rooms on Wednesday, August 14th, 1935, at 12.30 noon.

Those present were:

Dr. F. D. McKenty, Vice-President, in the chair
Dr. F. G. McGuinness — Dr. Ross Mitchell
Dr. J. S. McInnes — Dr. C. W. MacCharles
Dr. E. S. Moorhead — Dr. F. W. Jackson
Dr. F. A. Benner

The meeting was called to discuss the proposal of holding a Health Exhibition in Winnipeg under the auspices of the Back-to-the-Land Assistance Association some time in the fall.

The Association has been asked to co-operate in this exhibition and with the understanding that it would be completely under the association's control.

After considerable discussion and hearing a report by Dr. A. M. Goodwin, who had been appointed by the Executive to carry on negotiations with the Back-to-the-Land Assistance Association, it was moved by Dr. F. A. Benner, seconded by Dr. Ross Mitchell: That we co-operate with the Back-to-the-Land Assistance Association in putting on a Health Exhibition in the fall of 1935, providing that everything in connection therewith comes up to the requirements set out by the Manitoba Medical Association. —Carried.

Moved by Dr. E. S. Moorhead, seconded by Dr. J. S. McInnes: That Dr. A. M. Goodwin be convener of a committee, with power to add, to co-operate with the Back-to-the-Land Assistance Association in putting on this exhibition. —Carried.

Dr. Goodwin informed the meeting that the preliminary meeting was to be held Friday night, and it was moved by Dr. J. S. McInnes, seconded by Dr. C. W. MacCharles: That Dr. E. S. Moorhead and Dr. F. D. McKenty go with Dr. Goodwin to attend this preliminary meeting. —Carried.

There being no further business to put before the meeting, it adjourned.

POST GRADUATE COURSE, SEPT. 9-14

Arrangements for the Post Graduate Course, which is to be held at the Medical College, Sept. 9-14, have been completed. This course will lay special emphasis on the preventive aspects of medicine, dealing with such subjects as Trachoma, Diphtheria, Infant Hygiene, Mental Hygiene, etc. Among the guest speakers will be Dr. J. C. Meakens, Montreal, Dr. R. I. Harris, Toronto, and Dr. W. V. Cone, of Montreal. Clinical demonstrations in Medicine, Fractures, Dermatology and Varicose Veins are being arranged for out-of-town practitioners. The committee in charge of registration requests that all those intending to take this course mail in application forms to the Secretary, 216 Medical Arts Building, Winnipeg.

POST GRADUATE COURSE FACULTY OF MEDICINE

September 9 to 14

The post graduate course of the Faculty of Medicine will be held this year September 9th to 14th, inclusive. The course this year will deal principally with preventive medicine and public health and is arranged by co-operation with the Department of Health of the Province of Manitoba. In view of the fact that the clinical section of the Annual Meeting of the Manitoba Medical Association was held in May in conjunction with the Ontario Medical Association, the annual business meeting of the Manitoba Medical Association will be held during the week of this course.

In addition to the regular lectures there will be addresses by three clinicians from Eastern Canada: Dr. Meakins, Professor of Medicine at McGill and President of Canadian Medical Association, Dr. Cone of the Neurological Institute, Montreal, and Dr. Harris of the Surgical Department of the University of Toronto.

The outline of the tentative programme includes discussion of Diphtheria, Trachoma, Child and Maternal Hygiene, Cancer, Venereal Disease, Mental Hygiene, Chronic Respiratory Sepsis and Injuries and Infection of the Hand. Dr. Wall, Director of Trachoma Control, Department of Indian Affairs, will show a series of cases from the Indian Reserve.

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Members of the Manitoba Medical Association and all other medical men are urged to attend.

Report of the proceedings at an Executive Meeting held July 27, 1935.

1. Report progress on the activities of the Committee of Twelve.

2. Report from the Discipline Committee concerning an investigation of the actions of two doctors towards the Unemployment Relief Dept.

3. Report of the Taxing Committee regarding a case of insurance in reference to an automobile accident. This matter was brought before this Executive first on April 27, 1935. The Taxing Committee performed their very valuable work, their report being that the doctor's fee was quite reasonable. Since receiving this report, the lawyer to whom the Insurance Company paid over the total claim, has seen fit to pay the doctor his full fee, instead of as he tried to do, him to half his claim.

A copy of this report was forwarded to the Winnipeg Law Society.

4. Report that a Magistrate's conviction against J. P. Oshenak, Chiropractor, was sustained by the Manitoba Court of Appeal.

5. Report in reference to a certain doctor in the province using letters after his name, falsely representing qualifications which he did not possess, was presented to the meeting. Several letters had been written to him requesting an explanation for his assuming these qualifications and asking that he furnish a disclaimer from any such future action. As he had not replied to any of these letters the Committee ordered that he be summoned before the Discipline Committee for what action it may deem necessary.

6. Complaints lodged against four doctors required careful deliberation in each instance.

7. A request from Dr. R. F. Yule, Secretary, North Western Medical Society, stating "That the members of this Association reaffirm their previous resolution regarding writing the examinations of the Medical Council of Canada by subjects" was given due consideration. On two previous occasions such a resolution had been presented by the Council of Manitoba, but the Dominion Council had refused to consider our suggestion. The Executive Committee again passed a resolution asking that the Manitoba representatives again bring this question before the Dominion Council and urge its acceptance.

8. A letter was received some time ago from Dr. Laberge, Registrar of the College of Physicians and Surgeons of Quebec, asking for a meeting of the Registrars from all the provinces, to be held at the time of the Canadian Medical Assiciation meeting at Atlantic City. Your Registrar pointed out to Dr. Laberge that a more representative gathering would be assembled during the Annual Meeting of the Medical Council of Canada, as all Councils, except Manitoba, appointed their Registrars as delegates to the Dominion Council. Dr. Laberge accepted this suggestion and has arranged such a meeting. The Executive appointed Dr. Secord as a representative from Manitoba.

9. The question of nurses acting as anaesthetists was discussed. The Department of Hospital Services of the Canadian Medical Association has

been investigating the recognition of Nurse Anaesthetists in hospital practice, and a report furnished for the whole of Canada.

At present it is reported there are two nurses giving anaesthetics at the General Hospital and one at the Concordia Hospital in Winnipeg, also in some hospitals in outlying towns.

The Committee considered this question a very important one, and referred it to the next meeting of the Council.

10. The problem of maintaining a standard of Medical Education and Licensure, with the idea of evolving ways and means of having all licensed practitioners compelled to advance with the discoveries of Medical Knowledge was before the meeting. The Committee considered this a very important question and referred it to the Council.

11. Matters of primary and medical education were referred to the Educational Committee.

12. The question of Deontology (Duty and Medical Ethics) was referred to the Council.

13. Several communications were presented and received due consideration.

The meeting adjourned.

DISCIPLINE COMMITTEE

A meeting of the Discipline Committee of the College of Physicians and Surgeons of Manitoba was held in the office of the Registrar, 605 Medical Arts Bldg., Winnipeg, Wednesday, June 12, 1935, at 8.00 o'clock p.m.

The members present were:
Dr. R. J. Campbell, *Chairman.*
Dr. S. Bardal
Dr. A. E. McGavin
Dr. D. G. Ross
Dr. C. W. Burns

The business before the meeting was consideration of an account rendered by Dr. ....., Winnipeg, to the Unemployment Relief Department of the City of Winnipeg.

Dr. ....., of ....., Winnipeg, and Dr. ....., of ....., Winnipeg, were requested to appear before the Discipline Committee.

The Executive Committee considered this question at a meeting held April 27th, 1935, and by resolution referred it to the Discipline Committee for investigation.

Dr. R. J. Campbell read the following as the charge laid in this connection:

"Re. Mrs. ....., of ....., Winnipeg. This woman was operated on at the Winnipeg General Hospital on March 8th, at 9 p.m., and was charged for by Dr. ..... of ....., Winnipeg, appearing in his March account. On investigation it was found, both by this Department and the Committee on Sociology, that this operation was not done by Dr. ....., but was done by Dr. ..... Dr. .....'s account for March was much over the quota, being $132.00, and this Department feels that, in view of the circumstances, this account for $25.00 should not be paid. This Department, at the advice of the Committee on Sociology, is asking for a ruling on this case from the College of Physicians and Surgeons."

Dr. R. J. Campbell asked Drs. ..... if they had anything to say in this matter.

Discussion and questioning ensued regarding this case, and the following is the Finding and Recommendation of the Discipline Committee:

Finding.

"The Discipline Committee of the College of Physicians and Surgeons of Manitoba met in the office of the Registrar, 605 Medical Arts Building, Winnipeg, on Wednesday, June 12th, 1935, to consider the case of Dr. ..... and Dr. ....., as charged by the Unemployment Relief Department of the City of Winnipeg. Dr. ..... and Dr. ..... were present. It was admitted by Dr. ..... and Dr..... that Dr. ..... performed the operation. Under these circumstances, Dr. ..... should not receive compensation for his services in this case, as he was not actual operator.

"The rendering of such an account was an actual misrepresentation of fact. Both Dr. ..... and Dr. ..... claimed exoneration by pleading ignorance of the ruling that the operator only is entitled to render a charge for surgery on persons receiving Unemployment Relief."

Recommendation.

"We recommend that the Committee on Sociology send a short circular to every member in Greater Winnipeg, stating explicitly the rules in connection with the rendering of accounts to the Unemployment Relief Department, as it applies to this case. This will prevent pleading of ignorance in any future cases of this kind which may arise."

And Further, This Committee Recommends:

"That the report of the Findings and Recommendations of the Discipline Committee should be forwarded to the Unemployment Relief Department and the Committee on Sociology."

Clinical Week Programme

TUESDAY, SEPTEMBER 10

12.30 Complimentary Luncheon, Central Tuberculosis Clinic.
Guests of Sanitorium Board of Manitoba. Dr. Wherritt, Secretary of Canadian Tuberculosis Association, will be present.

2.00- 5.00 Maternal and Child Hygiene.
Chairman, Dr. F. G. McGuinness.
1. Infant Feeding—Dr. Gordon Chown.
2. Trends in Maternal Mortality — Dr. E. W. Montgomery.
3. New Thoughts on the Prevention of Maternal Deaths—Dr. Ross B. Mitchell.
4. Treatment and Prognosis of Puerperal Septicaemia—Dr. F. T. Cadham.

WEDNESDAY, SEPTEMBER 11

9.00-11.00 Symposium on Conditions predisposing to Cancer.
Chairman, Prof. William Boyd.
1. Gynaecological Lesions—Prof. D. S. MacKay.
2. Lip and Oral Lesions—Dr. M. R. MacCharles.
3. Skin Lesions—Dr. G. V. Bedford.
4. Gastrointestinal Lesions—Dr. P. H. T. Thorlakson.

11.00-12.15
1. Medical Clinic—Prof. C. R. Gilmour.
2. Fracture Clinic—Dr. W. A. Gardner.
3. Skin Clinic—Dr. A. M. Davidson.
4. Varicose Vein Clinic — Dr. C. E. Corrigan and Dr. W. A. McElmoyle.

These clinics limited to Practitioners outside of the City of Winnipeg.

12.30 Complimentary Luncheon—St. Boniface Hospital.

2.00 Venereal Diseases.
Chairman, Dr. S. C. Peterson.
Chairman's Address.
"Reduction of Morbidity in Venereal Disease."

2.30- 5.00 Five Rotating Clinics.
Early Syphilis, with demonstration of modern diagnostic and treatment methods.—Dr. S. C. Peterson.
"Our hope for the eradication of the plague of syphilis lies in its early diagnosis and adequate treatment."

Syphilis in Pregnancy.
Congenital Syphilis—Dr. Ross B. Mitchell.
"There is no excuse for the presence of congenital syphilis today."
Neurosyphilis—Its Diagnosis and Treatment—Dr. J. C. Hosack.
"Every potential tabetic and paretic can be diagnosed in the first year of his syphilitic infection and 95% of them can be completely cured."

Gonorrhoea, in the Male and Female—Dr. K. J. Backman.
"It is probable that, in the past, most of our efforts at treatment did more to retard and prevent cure than to aid in its accomplishment."

Trichomonas Vaginalis Vaginitis—with demonstration of cases and parasites and treatment methods—Dr. C. R. Rice.
"A very troublesome disease which is much more common than is generally known."

THURSDAY, SEPTEMBER 12

9.00-11.00 Mental Hygiene.
Chairman, Dean A. T. Mathers.
Guest Speaker—Dr. W. H. T. Mitchell, Mental Hygiene Institute, Montreal, assisted by Dr. W. M. Musgrove and Dr. G. L. Adamson. The purpose of this session being to acquaint physicians with some of the applications of Mental Hygiene and Psychiatry to problems met with in practice.

11.00-12.15
1. Medical Clinic—Prof. C. R. Gilmour.
2. Fracture Clinic—Dr. W. A. Gardner.
3. Skin Clinic—Dr. A. M. Davidson.
4. Varicose Vein Clinic—Dr. C. E. Corrigan and Dr. W. A. McElmoyle.

These clinics limited to Practitioners outside of the City of Winnipeg.

12.30 Luncheon and Annual Business Meeting of Manitoba Medical Association, Fort Garry Hotel.
Guest speaker—Dr. T. C. Routley, General Secretary, Canadian Medical Association.
President's Address—Dr. G. W. Rogers, Dauphin, Man.

3.30 Annual Golf Tournament — Manitoba Medical Association.

FRIDAY, SEPTEMBER 13

9.00-11.00 Chairman, Dr. E. S. Moorhead.
Visceral Infarction—Prof. J. C. Meakins, McGill University.
Diagnosis and Treatment of Tumours of Bone—Dr. R. I. Harris, University of Toronto.
Brain Abscess—Dr. W. V. Cone, Neurological Institute, Montreal.

11.00-12.15
1. Medical Clinic—Prof. C. R. Gilmour.
2. Fracture Clinic—Dr. W. A. Gardner.
3. Skin Clinic—Dr. A. M. Davidson.
4. Varicose Vein Clinic—Dr. C. E. Corrigan and Dr. W. A. McElmoyle.

These clinics limited to Practitioners outside of the City of Winnipeg.

2.00- 5.00 Diphtheria.
Chairman, Dr. E. W. Montgomery.
1. Diphtheria—Past, Present and Future Dr. A. J. Douglas, Medical Officer of Health, Winnipeg.
2. Diagnosis — Dr. Dugald McIntyre, Assistant Medical Superintendent, Municipal Hospitals, Winnipeg.
3. Treatment—Dr. E. F. Taylor, Municipal Hospitals, Winnipeg.
4. Prevention and Control—Dr. C. R. Donovan, Provincial Epidemiologist, Winnipeg.
5. Immunization Programmes—How to put them on. Dr. F. W. Jackson, Deputy Minister of Health and Public Welfare, Winnipeg.

SATURDAY, SEPTEMBER 14

9.00-12.00 Chairman, Dr. J. A. Gunn.
Head Injuries—Dr. W. V. Cone, Neurological Institute, Montreal.
Chronic Osteomyelitis—Dr. R. I. Harris, University of Toronto.
Prevention of Disability following Injuries and Infection of the Hand—Dr. A. J. Fraser, Chief Medical Officer, Manitoba Workmen's Compensation Bd., and Dr. Alexander Gibson.

Department of Health and Public Welfare

NEWS ITEMS

ALLERGY IN CHILDREN; Its treatment and Prevention. Robert Chabot, M.D.

The following is a copy of the first half of a report on "Allergy in Children, its treatment and prevention" written by Doctor Robert Chabot, which we believe will be of interest to the practising profession in the Province of Manitoba. Dr. Chabot's report will be completed in the next issue.

The prevention of the development of allergic manifestations is one of the important medical problems today. The picture, so frequently seen in adult life, unquestionably could be avoided if proper steps had been taken during childhood.

Bronchial asthma, eczema, and hay fever are the commonest manifestations of allergy in childhood, and make their appearance during the first three years of the child's existence in nearly half the cases. These children very frequently have a history of allergy in their families, but in at least half the cases this is not obtainable. Many observers have noted the fact that when one of these conditions occurred in both parental and maternal antecedents, the incidence of allergy was greater in the offspring than when only one was affected. These children with a bilateral family history have the occurrence of their symptoms at a much earlier age than where there is a unilateral history. There is little question, however, that they inherit a constitutional weakness which later, on proper contact, gives us the clinical signs of hypersensitivity. On the other hand, there is no evidence at all to show that there is any inheritance to the type of allergy that the parent is afflicted with. In other words, an asthmatic parent need not necessarily have a child with asthma, but one who may be afflicted with either hay fever, eczema or urticaria.

Asthma

In studying these children, one is struck by the overwhelming importance of upper respiratory infections either antedating or precipitating the first attack of asthma. The importance of pertussis, chicken-pox, measles, and pneumonia cannot be overestimated. Of the contagious diseases, pertussis is probably the most important as an etiological factor in the production of asthma.

The infectious diseases have concomitant sinus involvement as well as characteristic changes in the hilus glands of the lung. In many cases we see what probably is an initial sensitization to various bacteria as a result of having had either pertussis, measles, or chickenpox. Recent work in the production of a pertussis vaccine may be a great contribution toward the prevention of this disease and injections would act to remove it as a precipitating cause of asthma. Should these findings be substantiated by other observers, they will be of the greatest importance.

Nearly 60 per cent of the children suffering from bronchial asthma have or have had sinus involvement. The proper handling of these respiratory infections and the importance of building up the child's resistance are self-evident. Most of the children that we see have had their tonsils and adenoids removed, but too frequently do we see their recurrence which makes for reinfection. This initial bacterial sensitization, as a result of these infectious diseases, makes for repeated paroxysm on subsequent reinfection.

In a child with a background of allergy the early and complete removal of both faucial and lingual tonsils are indicated. This must be done before sinus infection has occurred, otherwise it is of little use. By and large, most of the children we see have been operated on far too late. An early operation might have cut down the number of cases of sinusitis that we see. However, a great many of these children are sensitive to an offending allergen such as dust, feathers, or foods which cause an adematous and a boggy nasal mucosa, which in turn is extremely susceptible to infection. The indication is treatment by means of injections for the patient's sensitivities to things such as dust and other offending allergens when they cannot be removed from the patient's diet. Unquestionably, treatment of this type of case results in the reduction of the patient's sensitivity and in a reduction of the number of paroxysms as well as in the bogginess of the nasal mucosa. By and large, in the case of food idiosyncrasies, removal from the diet suffices. Most of the children sensitive to foods lose that sensitivity without any treatment whatsoever, about the time they reach the age of five. However, unfortunately, they then become sensitive to the inhalant group. It is possible in some cases to prevent that sensitization by preventing contact with various animal danders and feathers. On the other hand, house dust is one of the mot frequent causes of trouble and, unfortunately, there is no way of preventing sensitization occurring to that substance, and for this reason injections must be used as the best form of therapy. In addition to injections of dust extract, precautions should be observed to keep the child's room free from dust-containing objects, especially feather pillows. The child should be given a hair mattress to sleep on, as many mattresses are stuffed with substances to which the child may be sensitive (for example: cottonseed). It is a wise policy to remove all rugs or drapes and to be sure that when the home is dusted, precautions are taken not to raise dust by dry sweeping.

One of the most important preventive measures is to treat these children with diphtheria toxoid and to Dick test them so that future injections of antitoxin made of horse serum will not be needed. Approximately one per cent. of our asthmatic children are spontaneously sensitive to horse serum, which is demonstrable by skin and ophthalmic tests. Early immunization certainly in these cases will avoid fatalities.

There has been a great deal written about bacterial hypersensitivity and bacterial skin tests to show hypersensitivity. Skin testing with bacteria has in the main, not been satisfactory. The use of vaccines made from the cultures taken from the infected area is justifiable. There is no evidence, however, to show any signs of permanent immunity resulting from their use. Those cases sensitive to the various inhalants offer the best chance of overcoming nasal complications. Where hyposensitization is undertaken with injections, the nasal mucosa loses its bogginess and sinus infections are lessened.

COMMUNICABLE DISEASES REPORTED

Urban and Rural : July, 1935

Occurring in the Municipalities of:—

Measles: Total 180 — Woodworth 53, Winnipeg 26, Blanchard 21, Strathclair 14, Lorne 12, Arthur 7, Souris 5, Roblin Rural 4, Melita 3, Minitonas 3, Unorganized 3, Brandon 2, Louise 2, Norfolk South 2, St. Vital 2, Virden 2, Gilbert Plains Village 1, Grey 1, Macdonald 1, Morden 1, Portage City 1, Rosser 1, St. Andrews 1, Tuxedo 1, Wallace 1, Winnipeg Beach 1. (Late Reported, May: Morris R. 1, Mossey River 1, Unorganized 2, Rhineland 1; June: Lorne 3, St. Boniface 1).

Whooping Cough: Total 128—Winnipeg 57, Brandon 19, Melita 13, Arthur 9, Kildonan East 8, Flin Flon 7, Louise 4, St. Boniface 4, Unorganized 3, Cornwallis 2, Woodlands 1. (Late Reported, June: Brandon 1).

Mumps: Total 105—Winnipeg 69, St. Boniface 12, Kildonan East 9, Miniota 5, Brandon 1, Kildonan West 1, Selkirk 1, St. Vital 1, Unorganized 1, Victoria Beach 1, Winnipeg Beach 1. (Late Reported, June: St. Boniface 4).

Chickenpox: Total 102—Winnipeg 68, St. Boniface 11, Roland 4, Kildonan West 3, Virden 2, Louise 2, Brandon 1, Brenda 1, Flin Flon 1, Hillsburg 1, Neepawa 1, Portage Rural 1, Souris 1, Springfield 1, St. James 1, Winnipeg Beach 1. (Late Reported, June: Brooklands 1, St. Boniface 1).

Tuberculosis: Total 54—Winnipeg 18, Unorganized 6, The Pas 3, Selkirk 2, Stanley 2, St. James 2, St. Laurent 2, Brandon 1, Brokenhead 1, Brooklands 1, Carman 1, Dauphin Town 1, Dufferin 1, Eriksdale 1, Flin Flon 1, Franklin 1, Gilbert Plains Rural 1, Montcalm 1, Piney 1, Portage City 1, Russell Rural 1, Springfield 1, St. Andrews 1, St. Boniface 1, St. Vital 1, Virden 1.

Scarlet Fever: Total 46—Winnipeg 10, Flin Flon 9, Kildonan East 2, Minitonas 2, St. James 2, The Pas 2, Argyle 1, Ft. Garry 1, Miniota 1, Montcalm 1, Portage City 1, Silver Creek 1, Strathclair 1. (Late Reported, June: Rockwood 10, Flin Flon 2, Unorganized 1).

Diphtheria: Total 15—Winnipeg 5, Rhineland 3, Morris Rural 2, St. James 2, La Broquerie 1, Macdonald 1, Portage City 1.

German Measles: Total 10 — Brandon 1, Lorne 1, Ritchot 1. (Late Reported, June: Kildonan West 4, St. Boniface 3).

Erysipelas: Total 5—Winnipeg 1, Brandon 1, Neepawa 1, Springfield 1, St. Vital 1.

Typhoid Fever: Total 4—The Pas 2, Hanover 1, Gilbert Plains Rural 1.

Influenza: Total 2—(Late Reported, May: Franklin 1, Minto 1).

Cerebrospinal Meningitis: Total 1—Winnipeg 1.

Puerperal Fever: Total 1—Rockwood 1.

Trachoma: Total 1—Unorganized 1.

Diphtheria Carriers: Total 1—St. Boniface 1.

Venereal Diseases: Total 91—Gonorrhoea 74, Syphilis 17.

DEATHS FROM ALL CAUSES IN MANITOBA
For the Month of June, 1935

URBAN—Cancer 38, Pneumonia (all forms) 11, Tuberculosis 9, Puerperal 3, Diphtheria 1, all others under one year 8, all other causes 166, Stillbirths 19. Total - - - - - 255

RURAL—Pneumonia (all forms) 26, Cancer 22, Tuberculosis 21, Puerperal 5, Syphilis 3, Infantile Paralysis 2, Influenza 1, Typhoid Fever 1, Erysipelas 1, all others under one year 4, all other causes 151. Stillbirths 15. Total - 252

INDIANS—Tuberculosis 14, all others under one year 2, all other causes 11, Stillbirths 1. Tl. - 28

Medical Library
University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. Holland, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"The Practitioner"—July, 1935.

"Radiology and Practical Medicine"—by Lord Horder, K.C.V.O., M.D., F.R.C.P.

"X-rays in General Practice" — by Cecil Bull, M.A., M.B., M.R.C.P.

"The Value of X-rays in the Diagnosis of Diseases and Injuries of the Skull"—by W. V. Coldwell, M.B., B.S., D.M.R.E.

"Radiology of Chest Disease"—by Franklin G. Wood, M.A., M.B., B.Ch., D.M.R.E.

"The X-ray Diagnosis of Abdominal Disease"—by Peter Kerley, M.D., D.M.R.E.

"Deep X-ray Therapy in Malignant Disease"—by Walter M. Leavitt, M.D., M.R.C.P., D.M.R.E.

"X-rays in Skin Diseases"—by A. M. H. Gray, C.B.E., M.D., F.R.C.P., F.R.C.S.

"Fulguration and Electro-Desiccation"—by E. P. Cumberbatch, M.B., F.R.C.P., and W. Douglas Harmer, M.Ch., F.R.C.S.

"Circumcision in Children" — by T. A. Ward, M.B., Ch.B.

"The Use of the 'Permanent' Jejunal Tube in the Treatment of Gastric Ulcer" — by W. Gilges, M.D., and F. Parkes Weber, M.D., F.R.C.P.

"Canadian Medical Association Journal"—July, 1935.

"Early Protected Weight bearing in the Treatment of Fractures of the Foot, Ankle and Leg" — by Fraser B. Gurd, F.R.C.S.(C), Montreal.

"The Clinical and Pathological Features of a Series of Twenty Cases of Hodgkins Disease"—by Edward S. Mills and Joseph E. Pritchard, Montreal.

"Acute Cholecystitis"—by James McKenty, M.D., F.A.C.S., F.R.C.S.(C), Winnipeg.

"The Antipyretics"—by V. E. Henderson, Dept. of Pharmacology, University of Toronto, Toronto.

"Canadian Public Health Journal"—July, 1935.

"The Provision of Medical Care in Western Canada"—by F. W. Jackson, M.D., D.P.H., President, Canadian Public Health Association.

—An address given in Toronto, June 3, 1935.

"Evaluation of Health Hazards in Industry"—by F. M. R. Butler, M.B., Division of Industrial Hygiene, Ontario Dept. of Health, Toronto.

"Contributions to the Laboratory Diagnosis of Amoebiasis from the Chicago Outbreak of 1933"—by Fred O. Tonney, M.D., and his assistants from the Section of Technical Service & Research Board of Health, Chicago, Ill.

"The New England Journal of Medicine" —March 14, 1935.

"Some Experiences in the Treatment of Young Diabetics, from the Point of View of the General Practitioner" — by Barbara Beattie, M.D.